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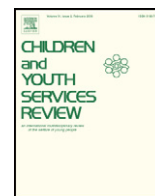
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A study of disabled children and child protection in Scotland – A hidden group?

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ABSTRACT

This paper is based on analysis of data collected for a study, commissioned by the Scottish Government, which examined child protection work with disabled children. At a conceptual level, the paper draws on Goffman's frame analysis and on different models of disability. Focus groups were conducted with five Child Protection Committees (40 individuals) and semi-structured interviews with a further 21 practitioners from social work, education, health services, third sector organisations and the police. The findings show that, for various reasons, abuse of disabled children may go undetected. Where it is suspected, effective action does not always follow, for example, where practitioners over-empathise with parents. When child protection work is undertaken, disabled children may remain relatively invisible in terms of participation and professional focus. It is suggested that the ways in which practitioners and managers "frame" disabled children has implications for how abuse is responded to and how well these children are protected. Participants also "framed" disability in different ways, and it is suggested that a social relational model seems particularly applicable. In conclusion, in many respects disabled children experiencing abuse may remain absent from or to some extent hidden within child protection services in Scotland. While some creative work is taking place, considerable changes are required to make child protection services accessible to all disabled children, sensitive to their needs and respectful of their rights.

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1. Introduction

This paper presents findings from a study, funded by the Scottish Government, which examined child protection practice with disabled children. The research was commissioned following previous scoping work by Stalker et al. (2010) which raised a number of questions about current practice, as well as informal reports to Government that some child protection practitioners were "struggling" in their work with disabled children. The following sections highlight key findings from other research about child abuse, child protection and disabled children. Next, we set out a conceptual framework for the current analysis, drawing on Goffman's frame analysis and different understandings of disability. The main findings are presented, followed by a discussion and consideration of their implications at conceptual, policy and practice levels.

Whilst the four nations of the UK have broadly similar child protection processes, Scotland's devolved powers in this regard mean that the system works slightly differently to that in England and Wales. The child protection system in Scotland follows a broadly public health approach under the auspices of "Getting it Right for Every Child" (Scottish Government, 2012), now enshrined in the Children and Young People (Scotland) Act (2015). This approach to child protection is more akin to other mainland European countries than it is to the broadly forensic systems operating in England and the United States for example (Gilbert et al., 2011). Scotland has a unique Children's Hearing System, whereby children and young people are referred to the Children's Reporter when an aspect of their life is causing concern (Children's Hearings Systems Scotland, 2015). Most referrals are from social services, the police and education, although anyone can make a referral. The Scottish Government (2014a) emphasises a collective responsibility for child protection, where local services work collaboratively through multidisciplinary Child Protection Committees to address concerns and notifications about children. Scotland retains a statutory child protection register, but interventions for children and families on the register or at risk of becoming so can be provided by a range of statutory and voluntary services. Where a child protection concern leads to out-of-home care, the state remains the child's guardian, but the placement may be provided by statutory or independent providers.

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1.1. The research context

Over the last ten to fifteen years, the majority of research about protecting disabled children has been conducted in the US, with relatively few studies elsewhere. Because research about this population covers children with different impairments and needs, this potentially reduces scope for comparison, so wherever possible in this section we identify the impairment groups covered by specific studies.

There is strong evidence that disabled children are more likely to be abused than their non-disabled peers. A meta-analysis of research about the prevalence of “violence” against disabled children, which examined 17 studies covering a “range of types of disability”, concluded that children with impairments are 3–4 times more likely to be abused than their non-disabled peers (Jones et al., 2012). This is a very similar finding to that of Sullivan and Knutson's (2000) methodologically rigorous study investigating prevalence rates which, having examined multi-agency records for 50,278 children and young people aged 0–21 in Nebraska, concluded that disabled children (defined here as all those needing “special education and related services”) are 3.4 times more likely to be abused than others. Further evidence about increased prevalence comes from Schenkel et al. (2014) about deaf children in the US, from Duan et al. (2015) about children with autism in China, from Reiter et al. (2007) about children with intellectual disabilities in Israel and, from the UK, about children with a range of impairments (Brandon et al., 2012; Stalker and McArthur, 2012; Stalker et al., 2010). Jones et al. (2012) reported that 20.4% of disabled children experience physical abuse, 13.7% experience sexual abuse while 26.7% face “combined measures of violence.” However, it appears that neglect is the most common form of abuse these children face (Stalker and McArthur, 2012).

In terms of impairment type, children with communication difficulties face three times the risk of abuse experienced by non-disabled children, those with intellectual impairments four times the risk, while those with “behavioural disorders” are at five times the risk (Sullivan and Knutson, 2000). A study examining administrative records of disabled children in out-of-home placements in Minnesota found that “emotional disturbance” was the most common disability among children whose maltreatment was “substantiated”, followed by intellectual disabilities (Lightfoot et al., 2011). Not enough is known, however, about the direction of causality, as some children acquire impairments as a result of maltreatment (Stalker and McArthur, 2012).

Lightfoot et al. (2011) found that in 22% of the Minnesota cases where maltreatment had been substantiated, the children were recorded as having an impairment. Such a high level of reporting appears to be unusual, however, with other studies suggesting that the abuse of disabled children is widely under-reported because the number of children referred to social services, and/or on child protection registers, is typically lower than might be expected, given the numbers of disabled children within the wider population and the higher prevalence rates noted above. Brandon et al. (2012) highlights this issue in relation to serious case reviews involving disabled children in the UK, as does Franklin (2015) regarding sexual exploitation of young people with learning disabilities. Perhaps linked to this, an Israeli study of 40,430 victims of sexual abuse, aged 3–14, found that children with “minor” to “severe” disabilities failed to disclose much more often than non-disabled children (Hershkowitz et al., 2007). Taylor et al. (2015) documented the barriers reported by deaf and disabled children and adults in relation to disclosing abuse. In October 2013, 5% of children on child protection registers in Scotland were recorded as disabled (Scottish Government, 2014b) while the disability status of 30% was unknown. According to the 2011 UK Census, 5% of young people aged 0–19 in Scotland have a disability or long-term health problem (see <http://www.scotlandscensus.gov.uk/ods-web/standard-outputs.html>; table DC3101SC). Therefore, it could be considered likely that a higher incidence of abuse among disabled children remains unreported in Scotland.

There is some evidence that the abuse of disabled children may differ from that directed at other young people. In relation to age, Sullivan and

Knutson (2000) reported that the typical “onset” age for “maltreatment” (a term they use to denote all forms of abuse and neglect) of children with certain impairments was 0–5, compared to 6–9 for non-disabled youngsters. Duan et al.'s (2015) study, reporting “widespread” physical maltreatment of autistic children in central China, focused on 2–5 year olds. In addition, boys are over-represented among disabled children who have been abused compared to the proportion of boys among non-disabled abused children (Sullivan and Knutson, 2000).

Disabled children are more likely than other children to be abused by a family member and to know the perpetrator (Miller and Brown, 2014). However, they are also vulnerable to abuse in care settings, including residential school (Stuart and Baines, 2004; Sullivan, 2009), foster care (Biehal, 2014; Biehal and Parry, 2010) and hospital (Sullivan, 2009). These studies suggest that deaf children and those with “behavioural disorders” are especially at risk in residential schools, children with learning disabilities particularly vulnerable in foster care while disabled children spending more than three months in a hospital may face increased risk. Looked after disabled children, especially those with learning disabilities, are also subject to various forms of child sexual exploitation (Lerpinier et al., 2013).

A US ethnography of child protection services for children with developmental delay found evidence of limited resources, including placement options and services to meet complex needs, plus inadequate disability training for staff (Shannon and Tappan, 2011). In England, “many disabled children receive good multi-agency early support but too many children had child protection needs which went unidentified,” according to an inspection of child protection work with disabled children in 12 local authorities (Ofsted, 2012: unpagged; paragraph 1). A UK-wide study, exploring deaf and disabled children's experiences of help-seeking following abuse, noted that professional responses were often inadequate: there were particular concerns about the quality of some foster care placements and a lack of professional interpreting services and communication support (Taylor et al., 2015).

In summary, while the above discussion is by no means a comprehensive review of the literature on child abuse/protection in relation to disabled children (for which, see Stalker and McArthur, 2012), it has highlighted evidence that disabled children are more likely to be abused than their non-disabled peers, that children with certain impairments are at increased risk and that the abuse of disabled children appears to differ in certain respects from that directed at non-disabled youth. The number of cases reported to child protection services typically appears lower than likely prevalence rates and, when maltreated disabled children are referred to services, they may not receive the same support as others.

Having outlined some key findings from the substantive literature, the next sections set out the conceptual basis of this paper. First, we introduce Goffman's frame analysis and then we consider different models of disability.

1.2. Frame analysis

Goffman (1974) developed frame analysis as a way to understand how people make sense of what takes place around them, whether that is conversations, actions or “wider” social phenomena such as particular social categories (for example, disabled children) or practices (like child abuse/child protection). Rather as a picture may be bordered by a frame, which gives structure and order to its contents, so Goffman perceived social actors “framing” situations and events with conceptual understandings they consider relevant to that event and according to governing social norms (Lemert and Branaman, 1997). Goffman used the term “strip” to refer to “any arbitrary slice or cut from the stream of on-going activity, including here sequences of activity, real or fictive” (1974: 7). He noted that people may apply different and sometimes opposing frames to the same strip, citing the example of the golfer viewing a round of the golf course as relaxation/recreation while the caddy sees it as work.

In developing frame analysis, Goffman drew, *inter alia*, on Schutz's (1967) concept of typification to denote the way people commonly attribute typical traits to people or events in order to make sense of them. These "stereotypes" do not correspond exactly to real people or processes but strive to capture and contrast their broad features. Schutz's influence can be seen in Goffman's concept of "keying", used to describe how a strip of activity or a social category can be transformed into a different kind of entity – or lent another reality – modelled on the original but "seen by participants as something quite else" (Goffman, 1974: 44). This can occur, for example, through a play, film, book or painting.

Goffman was also interested in "misframings". These can take many forms, including errors, for example, applying the wrong frame because one lacks full information about a situation, and ambiguities, when one is unsure how to define a situation. Frame disputes occur when arguments arise about what frame should be applied or what misframing, if any, has taken place (Burns, 1992). Framing can have both theatrical and potentially darker aspects, the former expressed in play, the arts or media, when reality is presented in "unreal" ways, the latter (darker aspects) through a process of "fabrication". This refers to "the intentional effort of one or more individuals to manage activity so that a party of one or more others will be induced to have a false belief about what it is that is actually going on" (Goffman, 1974:83). This might range from downplaying an unpalatable truth to maliciously deceiving others.

We now turn to different ways of framing disability, which may prove helpful in understanding professional responses to the abuse of disabled children.

1.3. Disability frames

Disability is a contested concept, framed in different and opposing ways. This section briefly outlines three of the most influential. The individual (often referred to as "medical") model of disability broadly equates to a "taken for granted", common-sense frame of disability, located within an individual and caused by illness or functional limitations. The professional tasks are cure, amelioration and/or rehabilitation (Oliver, 1990). Sometimes informed by a view of disability as a personal tragedy, the individual is given a passive sick role while practitioners act in the role of experts who "know best". The focus is on needs rather than rights. The individual model underpins significant advances in the understanding and treatment of disabling conditions.

In contrast, the social model of disability, developed by disabled academics and activists, frames disability in terms of society's economic, social and value base (Oliver and Barnes, 2012). It draws an important distinction between "impairment", meaning a physical, sensory or cognitive limitation, and "disability," referring to the social, material and cultural barriers which exclude people with impairments from mainstream life (UPIAS, 1976). Using this frame, disability is caused by social oppression: it is neither natural nor inevitable. The social model has proved highly influential in the development of anti-discrimination legislation and accessible public services in the western world and some majority world countries. However, it has been criticised for underplaying the effects of impairment and neglecting the diversity of individual experience.

In response to these perceived shortcomings, Thomas (1999, 2007) developed a "social relational understanding" of disability. This frame, located within the materialist tradition, is presented as a refinement rather than replacement of the social model. Thomas introduces two new concepts. First, "impairment effects" denote restrictions of activity on a person's day-to-day life resulting from specific impairments, such as the lack of energy associated with some conditions or an inability to do certain things. Such restrictions are not caused by social barriers: however, they may be exploited as a means by which to discriminate against disabled people, for example, if an employer were to refuse a blind person a computer-based job on the grounds of her visual impairment, rather than purchasing assistive software. Thomas's second

concept, "psycho-emotional disablism" refers to hurtful, hostile or inappropriate behaviour from others which disabled people may experience on a regular basis. Over time, she argues, this has a negative effect on a disabled person's sense of self, affecting what they feel they can be or become. Psycho-emotional disablism operates at both one-to-one and institutional levels. The concept has been further developed by Reeves (2012).

2. Study aims and methods

This research was commissioned to inform the work of the Scottish Government Ministerial Working Group on Child Protection and Disability, set up in 2012.² The main research aim was to assess how public services in Scotland identify and support disabled children and young people at risk of harm. Research questions focused on decision-making processes and "triggers" for intervention, co-ordination of services, and identifying useful practice examples. The age range for "children and young people" was 0–21. A social model approach was taken to "disability", including young people with physical, sensory, intellectual and communication impairments, mental distress and those on the autistic spectrum. Our remit did not extend to seeking young people's views about child protection: the authors have recently completed another study focusing on this (Taylor et al., 2015).

Ethical approval was gained from the University of Strathclyde taking account of confidentiality, anonymity and informed consent. Had a participant identified unaddressed child protection risks to a young person, such information would have been referred to an agreed named person.

Six Scottish local authorities were invited to participate in the study, representing variation in size, urban/rural dimensions and the number of disabled children on their child protection registers. Focus groups, exploring policy and strategic issues, were conducted with Child Protection Committees (CPCs) in five of these authorities. CPCs are multi-disciplinary groups responsible for co-ordinating inter-agency work across a local authority. Each focus group comprised between 3 and 12 participants, with a total of 40. Information sheets and consent forms were distributed by CPC Chairs and Lead Officers.

Twenty-one semi-structured interviews took place with practitioners from health, education, social work, the police and third sector organisations across the six authorities. Managers in each agency were sent an information sheet and consent form and invited to nominate appropriate respondents. Care was taken to design balanced interview schedules and topic guides which had open questions and were not unduly problem-oriented. The interview schedule used with individual practitioners had a practice focus: it invited them to relate an example of one "good" and one "more challenging" case they had worked on, explored awareness of prevalence and risks facing disabled children, and sought views about thresholds for action, appropriate interventions, involving disabled children in the child protection process and any challenges within the child protection system with respect to disabled children. The topic guide used in focus groups with CPCs had a more strategic focus: its themes included identification of child protection concerns in disabled children, identification/recording of impairment in children, inter-agency working (enablers and barriers to co-ordination) and staff training. With participants' permission, all interviews and focus groups were digitally recorded and data fully transcribed.

Analysis conducted for the Scottish Government end-of-award report identified that disabled children may be a hidden or "absent" group within child protection. This paper aims to explore that theme in more detail and, for this, a second, more focused analysis was conducted, drawing on Braun and Clarke's (2006) framework for thematic analysis. This "works both to reflect reality and to unpick or unravel

² The group's other main output, a Disability and Child Protection toolkit, can be seen at <http://withscotland.org/exchanging-training-resources>.

the surface of ‘reality’” (p. 81), fitting well with frame analysis. The first step is to become familiar with the data: thus each transcript was carefully re-read, identifying points and issues (codes) deemed relevant to the selected topic. Next, all data for each code were brought together and reviewed and some codes were merged; e.g.: “talking to children about child protection” was merged with “seeking children’s views” while some sub-codes were created, reflecting different aspects of a phenomenon. Next comes “searching for themes”: in this case, codes were grouped into three larger themes which, placed sequentially, can be seen to organise (frame) the overall story. These themes were: “identifying child protection concerns about disabled children”, “acting on concerns” and “placing the child at the centre of practice.” The findings are presented below under these three themes.

3. Findings

3.1. Identifying child protection concerns about disabled children

3.1.1. Variable awareness of the prevalence and nature of abuse of disabled children

Participants had varying levels of awareness about disabled children’s heightened vulnerability to abuse. The consensus in three CPCs was that no conclusive research exists about prevalence, with no broad trends or specific issues relating to disabled children being identified in their areas, reflected in the low numbers on their child protection registers. They were “confident” they were not missing cases; indeed, a participant in one CPC argued that disabled children might be better protected than others because they had extensive support packages, often involving one-to-one care which provided opportunities for disclosure. Several participants did not know whether or not disabled children were at greater risk than non-disabled children.

In contrast, two CPCs and about half the practitioners interviewed believed that abuse of disabled children was higher than for other children and, as one social work manager put it, higher than “our data and practice reflect,” a view they based on research, practice experience or supposition, and supported by studies cited earlier in this paper (Brandon et al., 2012; Hershkowitz et al., 2007). One-to-one care, communication difficulties and social isolation were identified as increasing risk of abuse and reducing children’s ability to disclose. A social work manager commented:

I think there are children that are not on the radar and it needs to be better actually, try to improve public awareness...[also] raising awareness amongst indirect staff who do not deal with child protection issues on a daily basis, so they don’t have the understanding that perhaps social work and education do.

Nearly all participants thought that, among disabled children, those with communication impairments were likely to be most vulnerable. However, there was less awareness about risks associated with other types of impairment, gender or age (reported in Section 1.1).

3.1.2. Losing sight of the child

One danger identified by six participants and one CPC was that signs of abuse could be attributed to aspects of a child’s impairment and thus go unrecognised. This applied both to physical signs such as injury and to changes in a child’s behaviour denoting distress:

If you’ve got a child that’s maybe physically head-banging or whatever and got bruises and self-assaulting themselves or whatever, then it would be more difficult to see that they’ve been caused by someone else if they’ve done that to themselves before...or a child that’s got developmental delay or communication difficulties, if they’ve been emotionally abused.

Fourteen practitioners expressed concerns about the potential consequences of allowing communication impairments to become a barrier:

If you start off from a position where communication is problematic then I think there are people who are going to be subject to abuse that we are not aware of and that worries me a great deal.

It was also reported that parents sometimes tried to dissuade practitioners from speaking to children by “talking down” the young person’s level of ability or awareness. This might be in an overly protective way or for more sinister reasons where they were the perpetrators.

3.1.3. Losing sight of the child’s impairment

While three CPCs and 14 practitioners emphasised the importance of a “child-centred” approach to protecting children, there were differing interpretations of how this applied to disabled children. Three CPCs reported that these children were treated just like any others, using the same policies and procedures: the low numbers of registered disabled children may be because “we’ve cracked the ‘child first’ thing”. One group expressed “discomfort” and another irritation with the “unhelpful” focus on disabled children in our study. They preferred to see disabled children as part of a wider group, either “any other children” or those with “additional support needs” — a term used in Scottish legislation to refer to young people requiring extra help for a range of reasons. One manager who took this view commented:

“Communication impairment?” — I don’t know what that is, don’t recognise it. I think people have difficulty communicating within a bigger spectrum of [factors].

Two CPCs took a different view. While agreeing that in many respects disabled children should be treated in the same way as others, it was also important to look at their different needs and particularly any communication difficulties. Staff required specific skills, including communication skills, to identify and deal with cases involving disabled children. A CPC member commented:

There is not a level where a child with a disability doesn’t become more vulnerable because of the disability that they have.

Six highlighted the importance of practitioners having information about the specific impairments/medical conditions of the children they worked with and also any medication regimes. This would help them distinguish between impairment/medication effects and indicators of abuse.

3.1.4. Social isolation

Disabled children can be socially isolated, spending a good deal of time at home with their families (LTCAS, 2010), often with fewer friends than their non-disabled peers (Sylvester et al., 2013). Social isolation can contribute to abuse going undetected:

They are more likely to be in a family that has experienced poverty and [is] on benefits, more likely to have impaired social networks. And the isolation can be such a big one that who is there to listen to them and build up confidence and competence in terms of strategies for dealing with situations?

One boy had been kept off school for over two years by his single parent mother on the fabricated grounds that he had a “school phobia”, a situation which our respondent believed would not have been allowed to continue uninvestigated so long for a non-disabled child.

One participant commented: “Even though [a concern] is identified, whether it is taken forward is another issue”. The next section considers the reasons for this.

3.2. Acting on concerns

In this section, we identify a number of factors which sometimes prevented practitioners from taking prompt and effective action for disabled children, even when a child protection concern had been identified.

3.2.1. Empathising with parents and losing sight of the child

Previous research in the UK and US has highlighted a danger that practitioners working with families with disabled children may over-empathise with parents and “take their eyes off” the child (Manders and Stoneman, 2009; Miller and Brown, 2014; Ofsted, 2012). This practice was identified by four CPCs and six participants in the current study. It resulted from practitioners perceiving parents struggling to cope with the demands of caring, often in difficult circumstances, and feeling sorry for them. A CPC member believed some practitioners have “a kind of feeling that [disabled children] are so hard to look after, you almost lower your standards in terms of what is acceptable.” A health professional commented:

Sometimes there are children that come in, I can think of them in wheelchairs and stuff, who've got bruises and things, and actually at the end of the day when we've explored it further, they probably have been slapped and roughly handled, but I think it's difficult and I think there's always this emotional thing with people about...you don't want to accuse carers because they have a difficult time looking after their children who've got gross disabilities.

Where workers had built up “really strong bonds” with parents over time, it was difficult to raise child protection concerns. A third sector representative argued that practitioners need to be aware of the stresses facing families with disabled children and avoid placing “undue pressure and expectations on them”. Two practitioners, however, said that over-empathising with parents could result in practitioners “colluding” with them, failing to identify abuse or even joining parents in “blaming” the child for “bad” behaviours possibly associated with impairment or indicative of abuse. This, we were told, could lead practitioners to focus on supporting the parents while the child's needs remained neglected. Manders and Stoneman (2009), who invited child protection workers in the US to comment on a series of vignettes of potentially abusive situations, found that disabled children were sometimes seen as having characteristics which contributed to the abuse.

3.2.2. Applying thresholds for action

A “threshold” can be thought of as the point at which concerns about a particular child's safety reach the level where action must be taken. However, a number of threshold points may arise as a case progresses and different practitioners/agencies may hold differing views about when a threshold has been reached. Scottish Government (2014c: 7) guidance on protecting disabled children from abuse and neglect stresses:

Concerns should be shared at the first opportunity either with an appropriate manager or with the designated member of staff who has responsibility for child protection in the agency/service provider, so that a referral can be made promptly.

Ten practitioners and two CPCs in this study thought that lower thresholds were applied for disabled children than for others, because the former were seen as more vulnerable and less resilient:

I think people might be, you know, that's a lower threshold, I think they're definitely erring on the side of caution, recognising that there are additional needs there and that the person is more vulnerable.

Six practitioners believed thresholds were applied more or less equally irrespective of impairment. However, three professionals who said the same thresholds applied to all children nevertheless cited an example of a high threshold being used for a disabled child. For example, a health professional had examined a 10 year old boy for injuries, which he alleged his stepfather had caused, on five occasions:

... which was obviously very concerning to me, that maybe action hadn't been taken previously... I wonder whether because of his difficulties, his disclosures were being minimised because people weren't really understanding him.

A police officer from another authority reported that one child had not been placed on the register but remained with a children's disability team (primarily a family support team which may not have child protection expertise), because “the disability was more significant than the neglect.” It was not thought possible to interview this child because of her communication impairment, even although she had disclosed that her parents and siblings had been hitting her.

Three practitioners and two CPCs said thresholds were higher for disabled children and several (drawn from all sectors) perceived social services applying higher thresholds than their own/other agencies. Examples were given of disabled children having been left for some time (years in two cases) in what some practitioners perceived as high risk situations:

Children are just left at home for far too long, living in squalid conditions with huge amounts of neglect and then the whole emotional or behavioural fall-out that comes with that.

The following case example illustrates conflicting views about appropriate thresholds, based on different framings of what was going on in one family.

Case example of Baby Joe, related by his social worker.

Joe was born prematurely to a young mother with limited capacity and no previous children. Joe's chromosomal disorder caused him to be very frail, have poor muscle tone and difficulty absorbing nutrition, thus failing to thrive. Hospital staff believed that Jane, Joe's mother, would never be able to cope. When he eventually left hospital after birth, the family's health visitor became concerned about Joe's weight loss, which she attributed to parental neglect, and by what she perceived as a “very dirty” house. A case conference was held and Joe was placed on the child protection register. The hospital reported that Jane frequently failed to bring Joe to medical appointments, construed as another sign of neglect.

As Joe's social worker gradually got to know the family, she identified several misconceptions at work. The health visitor was not familiar (and had not looked into) the implications of Joe's condition. The hospital was giving Jane multiple appointments — at worst, 14 in one week: she had attended some, but could not afford the taxi fares for all of them. (Traveling by bus with Joe was almost impossible due to his breathing apparatus.) The social worker arranged for the medical appointments to be better co-ordinated and a social work assistant was found to accompany the family to hospital. A speech and language therapist was employed to assist with Joe's swallowing reflex to improve his eating. Jane was supported to apply for a carer's allowance and home care was brought in on a short-term basis to clean up the house. The combined success of these measures led to Joe being removed from the child protection register.

In contrast to the medical opinion, the social worker perceived Jane as “a damn good mum... she knows right from wrong and how to keep her child safe.” Different framings of the child (seriously neglected or having a serious medical condition) and the mother (incapable and neglectful or capable enough but needing support) led to conflicting views about both the root and nature of the problem and the appropriate interventions to make. Fortunately in this case, the social worker was skilled in uncovering the misframings, negotiating with other agencies and securing appropriate support for the family.

3.2.3. Staff training

The level and focus of training which participants had received to prepare them to undertake child protection work with disabled children

was variable. Only four had received training in communicating with disabled children, over half had received very little or no such training while eight wanted more. Only two had been trained in child protection work specifically with disabled children. Three practitioners relied on “individual learning”, “experience” or “common sense”. A social worker from a third sector agency commented:

What you find is that you muddle through quite a lot of your cases with children with disabilities and it's dependent on your own learning. ... and actually quite often they don't receive the same service as children who are classed not to have a disability.

Another social worker gave a good practice example of the difference training in Makaton (a simple signing system used to support speech) had made to her work with a young girl with intellectual disabilities:

The parents were very resistant to social work ... but the fact that I was able to speak to the girl and not [just] to them, or not over her, was a real icebreaker and that's been a real benefit...I think it strengthened relationships and strengthened trust.

Two CPCs with less awareness of disabled children's heightened risk provided “generic” child protection training; another was investigating the need for training about protecting children with “additional support needs”. In contrast, the other CPCs recognised the need for more training in both communication skills and child protection work with disabled children.

3.2.4. *Locus of responsibility*

Three participants questioned whose responsibility it was to protect disabled children, with one social worker stating that this should not be part of “mainstream” social work. This was justified on the grounds of current heavy workloads demanding long hours and the perception that much time was needed to develop relationships with disabled children. Instead, children's disability teams should take on this work. However, another respondent described such teams as “the unseen, unheard service”, being smaller and having fewer resources than child protection teams. Young et al. (2009) cited in Miller and Brown (2014), found that children's disability teams were often ineffective in meeting deaf children's needs.

3.3. *Placing the child at the centre of practice*

For some years, the overarching framework for children's services in Scotland, now endorsed in the Children and Young People (Scotland) Act 2014, has been Getting it Right for Every Child (GIRFEC). Children must be placed at the centre of practice, outcomes must be improved and all agencies should respond appropriately to individual children's needs and any risks they may face. This section considers how far child protection work with disabled children reflects this policy.

3.3.1. *Communicating with disabled children*

Good communication is key to placing any child at the centre of practice. Research and guidance have been published about communicating with disabled children (e.g., Murray, 2012; Triangle, 2012). Key messages include that every child can communicate at some level and that a choice of communication methods should be provided. Most respondents in this study stressed the importance of adapting the level, nature and format of communication to suit individual children and many different methods of doing so were identified. Six recommended using observation to gauge children's feelings and well-being, focusing on behavioural changes and, in non-verbal children, subtle signs like the meaning of different noises a child might make. A recurring theme was the necessity of communication being led or guided by a professional who knew the child well and was attuned to her communication style, as well as being trusted by the young person. A third sector worker described how she approached working with a boy on the autistic spectrum:

I guess just seeing the child for who he is, you know...engaging with the child and relating to him as a wee person in his own right...I mean certainly I just tried to enter his wee world and as I say, I just took the lead from him.

However, communicating with disabled children proved an obstacle for many practitioners. A social worker described it as her child protection team's “biggest challenge” while another noted that some investigative reports simply stated that staff could not communicate with a non-verbal child. Three practitioners and one CPC referred to staff feeling anxiety and even “fear” at the prospect of working with disabled children. Seven practitioners and one CPC reported negative attitudes (theirs' or their colleagues') towards communicating with disabled children; for example, it was not their responsibility to do so (social work, health, police); communication aids were difficult to use and “most” disabled children were “too disabled” to communicate.

3.3.2. *Seeking disabled children's views about child protection concerns*

Practitioners were keen to emphasise the importance of seeking disabled children's views about child protection concerns – “as for any other child”, “always”, “if they are over 2 and have vocabulary – yes”. A few stressed the need to seek the child's views separately from the parents' and to avoid assuming a disabled child had the same views as her siblings.

Sixteen practitioners typically involved or sought the advice of colleagues who knew the child well, either before deciding whether to raise concerns with the child or during the investigation, highlighting the importance of multi-agency working. Various ingredients of a successful interview were identified: careful planning and preparation, a child-friendly venue, the right time of day to suit individual children's needs, communication aids and facilitators as appropriate. Participants sought to identify any worries or special needs a child might have, explain the process, be honest about the concerns, adopt an informal approach and use simple language. Children's views had been sought on their feelings about leaving or returning home, their care and place of residence, their understanding of the current situation, its impact on them, their feelings about other key players and/or wishes for the future.

On the other hand, an example of potentially weaker practice (although not presented as such) was reported by a third sector worker. She recounted an incident where a non-verbal child who had presented with bruises was not asked about them, although he used Makaton, while the parent's explanation that their son had started nipping himself was accepted, apparently unquestioningly.

A study of children's advocacy services in Scotland, found significant gaps in provision for those who were disabled or had mental health issues (Elsley, 2010). Therefore it may not be surprising that, asked if independent advocacy was ever provided to disabled children within child protection, only a few respondents (drawn from three authorities) said that it was. Good advocacy increased professional understanding of the child's views and wishes but communication difficulties could still be a barrier, in which case, we were told, advocates may report parents' views rather than the child's.

National Child Protection Guidance (Scottish Government, 2014a) states that consideration should be given to inviting children to Child Protection Case Conferences (CPCs), taking account of their age and the potential emotional impact of attending. Practitioners should consider whether disabled children will need support to express their views. In this study, it was reported that disabled children seldom attended CPCs although there were exceptions. Good practice included supporting young people's inclusion by providing a special seat or arranging attendance for part of the meeting only. However, other children had become upset or “disruptive” during the meetings while, according to a police officer, one CPC had focused strongly on the mother's needs – the perpetrator's – rather than the child's, despite the latter being present.

4. Discussion

In this section, we return to Goffman's frame analysis as a lens through which to view the findings or "strips" of reported activity. As mentioned earlier, Goffman drew on Schutz's (1967) concept of typification, the social practice of attributing typical traits to people or events in order to "figure them out". Applying this frame to our findings, we see that participants framed disabled children in three ways. It is not suggested that every, or indeed any, participant subscribed to all the perceptions associated with any one category.

4.1. Framing disabled children

4.1.1. Disabled children framed as different/other

Here, disabled children were framed as different from others and difficult to relate to, largely because of their impairments, which were an "unknown", and particularly because of their (real or perceived) communication difficulties. Communication aids were seen as difficult to use. The prospect or practice of child protection work with disabled children aroused discomfort, anxiety or even fear. In addition, it was awarded low priority because it was neither "interesting" nor "sexy" (words used by participants). Despite Scottish Government policy that everyone (practitioners and public) shares responsibility to ensure that children are safe, a few practitioners did not think that working with disabled children should be part of "mainstream" child protection work. Some said they did not have the time needed to develop relationships with disabled children and that this should be the remit of children's disability teams.

Framing disabled children in these terms could lead practitioners to relate to parents rather than child, empathising with the "burden" they face, seeing the child as responsible for stress or behaviour problems. The impairment and the difficulty of caring for the child took on more significance than concerns about abuse or neglect, with the result that thresholds for action were raised. The outcome could be that disabled children are less protected than their non-disabled peers, possibly exacerbated by an institutional framing (under-valuing) that provided inadequate resources for doing so.

4.1.2. Disabled children framed as the same as any others

Participants using this child-centred frame saw the child first and the impairment as secondary. An "inclusion" frame was applied which equated disabled children with others in a generic but sometimes unthinking way. This led to the view or assumption that disabled children should be treated in the same way as any others, introducing a risk that specific impairment effects might be minimised or missed. Similarly, disability, in the wider sense of external barriers, might not be taken into account: for example, devaluing social attitudes may heighten disabled children's vulnerability. Disabled children were thought to face the same level of risk as others and, in some cases, to be better protected through regular use of services: consequently, some agencies appeared to believe that when isolated cases of abuse occurred, they were readily identified and managed. Similar thresholds were applied to all children; generic child protection training was considered adequate for working with disabled children. Where possible, their views should be sought like any child's. There is a risk that one outcome here, as above, is that disabled children receive less protection than others.

4.1.3. Disabled children framed as equal and different

This is another child-centred frame, with a child-first view, but taking account of impairment effects and psycho-emotional disablism (Thomas, 1999, 2007) and wider barriers. There was awareness of disabled children's heightened vulnerability, risk factors, the under-detection of abuse and widespread negative attitudes towards disabled people. It was professionals' responsibility to address such barriers. Lower thresholds were likely to be applied due to disabled children's perceived vulnerability and lesser resilience. Time and effort must be invested in building rapport with individual children and seeking their

views, enabling them to exercise agency as far as their abilities and circumstances permitted. It was seen as a child's right that practitioners be able to communicate with them, not a "bonus". Reasonable adjustments were made where appropriate to ensure disabled children were treated equally to others and staff needed specific training to equip them with the skills, knowledge and confidence for this work.

A case study example next illustrates these different framings and how they may interact unhelpfully, with implications for child protection.

Case study of Tom, illustrating different framings (based on an interview with Kate, a third sector support worker).

Tom was an 11 year-old boy with learning disabilities, autism and attention deficit hyperactivity disorder. He had previously lived with his mother, suffering years of neglect, but now lived with his father and older brother in social housing. Practitioners had some concerns about his father's parenting capacity. Kate, a third sector worker supporting the family, found it hard to tell if certain issues, for example Tom's difficulties with eating and impulse control, were due to his impairments, his past neglect or possibly inadequate care currently.

The family was currently under threat of eviction. Neighbours had made various complaints to the housing department about Tom's behaviour and early morning disturbance caused by a "noisy" school bus collecting him. The family had a poor reputation in the local area and the housing officer lacked awareness of the implications of Tom's impairments. Kate commented: "There was lots of hearsay and things being said in the community that the housing officer was taking as standard." In addition, Tom's father was resistant to his son's impairment being made explicit, to protect him from stigma. Thus, the community and to some extent the housing officer, could be said to frame Tom as "different and other" while his father framed Tom, or at least framed him to other people, as "the same as" other children.

Because there wasn't a "shared understanding of the difficulties" among practitioners or between family and practitioners, in Goffman's terms, a *frame dispute* — Kate decided to set up a "working group." The aim was to bring everyone together to share information and reach agreement on how to proceed. A medical opinion was needed to clarify how Tom's conditions and medication might impact his eating and to distinguish between impairment effects and possible signs of abuse, while the housing department need to learn more about Tom's impairments. Tom attended part of the first meeting with his brother and father, where he stated: "I don't want to move house; I don't want my dad to lose his house". This was "quite a clear message," Kate observed; "It was useful for [everyone] actually to have the young person there to see who it was they were talking about, rather than this quite often demonised 11 year old...we were talking about an 11 year old child with learning difficulties." Thus, Kate framed Tom as "equal and different". The eventual outcomes were; concerns about continuing neglect abated, the family was not evicted and Tom's father became more open about his son's challenges. The case was closed when Tom reached 14.

This example illustrates the conflicting ways in which Tom himself, and the challenges he faced, were framed by his father, various practitioners and the local community. These differences interacted to cause confusion, uncertainty, anxiety, anger and prejudice, as well as a real crisis in the form of imminent eviction. Fortunately, these issues were resolved due to Kate's skills in bringing people together to reconcile differences and reach solutions, the protagonists' eventual willingness to consider the situation afresh and, perhaps also to some extent, Tom's own agency.

4.1.4. Other aspects of framing within child protection work

The study findings revealed a number of other features of framing (Goffman, 1974) within child protection practice. First, illustrating the fragile nature of framing, there were several examples of *misframings*. There were *errors*, for example, about the prevalence of abuse of disabled children (Jones et al., 2012), which impairment groups faced heightened risk and the forms of abuse they experienced (Sullivan and Knutson, 2000). There was *ambiguity*, for example, where practitioners were uncertain if disabled children were at greater risk than others. There was *misidentification*, for instance; attributing signs of abuse or distress to impairment; failing to see the implications of impairment effects, powerfully illustrated in Baby Joe's case, and focusing on parents' needs at the expense of the child's. Situations of abuse or neglect were not always recognised as such or, some participants implied, were framed as less harmful to disabled children than to non-disabled children. Other instances of misframing concerned children's ability to communicate and disclose information, evident in the generalised assertion that disabled children are "too disabled" to communicate but also where a child *had* disclosed yet was deemed unable to be interviewed and the information was not acted upon. Myths and stereotypes relating to the abuse of disabled children are also reported by Miller and Brown (2014).

Goffman also refers to *fabrication*, ranging from self-deception to deliberately deceiving others. In this study, there were instances where participants may have tried to avoid issues that gave rise to discomfort, such as facing up to the significance of low numbers of disabled children on child protection registers, or telling themselves (and others) that these children are better protected than others. More deliberate reported examples of fabrication included parents talking down a child's abilities to dissuade professionals from speaking to her or inventing a school phobia, while practitioners created potential for fabrication when they relied on parents to interpret for a child, or supply a child's history.

4.1.5. Framing disability

Also evident within the findings are contrasting ways to frame disability. Strong elements of the individual or medical model can be discerned where disabled children are primarily seen in terms of impairment and/or burden and where signs of abuse or distress are mistakenly attributed to impairment. The view stated in one case, but perhaps implicit in others, that impairment is more significant than neglect, also belongs here. Using a social model frame to critique this stance, a failure to recognise that disabled children are not on an equal playing field with non-disabled children and to provide reasonable adjustments results in discrimination. The role of social exclusion, material deprivation and prejudicial attitudes in placing disabled children at risk are highlighted within a social model frame. Inadequate resources and failure to tackle communication barriers exacerbate the problem, the way forward, in social model terms, being to tackle disabling barriers and implement disabled children's rights.

Important as these insights are, a more comprehensive and nuanced approach is available through a social relational frame (Thomas, 1999, 2007) described earlier in this paper. The significance of impairment effects is evident in much of the data: a child with communication impairments may not be able to report abuse; a child with visual impairment may not see the abuser; a child with mobility difficulties may not be able to remove herself from the abuser; and a child with intellectual disabilities may not know that abuse is wrong. Within Disability Studies, the home of the social model, these are likely to be controversial statements. Although Disability Studies has paid little attention to child abuse, there is much interest in "hate crime" against adults. The notion that disabled people are inherently vulnerable because of impairment, and in some way attract or are "responsible" for violence directed against them, is strongly disputed, violence being explained in terms of hatred and hostility (Roulstone and Sadique, 2012). Evidence of these as motivational factors is, however, thin and the calculation that

it may be easier to get away with abuse of a disabled as opposed to a non-disabled person may be influential. Finally, psycho-emotional disablism (Reeves, 2012) is a constant theme in this study, most obviously in terms of abuse itself but also at times within professional responses.

5. Conclusion

In conclusion, this paper has argued that the way practitioners and managers frame disabled children can result in more or less awareness of the risks they face, and higher or lower levels of protection. The study findings provide evidence that in many respects disabled children experiencing abuse may remain absent from and/or hidden within child protection services in Scotland. First, there are indications that their abuse may go undetected, in which case they would not enter the system. This can happen due to low awareness among practitioners of the higher prevalence of abuse among this population, misunderstandings about the abuse of disabled children, the social isolation which some disabled children experience and/or an imbalanced focus on either the child being like any other young person or else on her impairment, resulting in missing or misinterpreting signs of abuse. The low number of disabled children on child protection registers in Scotland adds strength to this argument.

Secondly, if/when concerns are raised or abuse is suspected, disabled children may still not be referred to services or, if they are, may be accorded low priority. Sometimes this is because practitioners over-empathise with parents and neglect the child's needs, because training in safeguarding and communicating with disabled children is inadequate or because resources may be insufficient. In addition, some mainstream practitioners are anxious about working with disabled children or believe they should be referred to disability services. The high number of children on child protection registers in Scotland whose disability status is unknown also suggests a level of invisibility.

Thirdly, when child protection work is undertaken with disabled children, they may still remain relatively hidden, or less visible than non-disabled children, in terms of voice and professional focus. This occurs when practitioners fail to seek their views, provide independent advocacy or facilitate attendance at CPCCs. However, it must be emphasised that, while there is considerable room for improvement, some sensitive and creative work is taking place. Professionals perceive disability in different ways, and may use elements from more than one model in their work, although we would argue that a social relational approach is the most useful.

Given that these findings echo research conducted internationally, discussed in the [Introduction](#), the policy and practice implications extend well beyond Scotland. Child protection services need considerable adaptation to become fully accessible to disabled children, sensitive to their needs and respectful of their rights. Mainstream child protection teams should be responsible for working with disabled children although staff must know where and when to seek specialist advice. Disability services need sufficient training in child protection to identify causes for concern and the importance of passing these on to child protection colleagues. Additional specialist support should be more readily available and used at an early stage in the investigative process.

Professionals in all sectors working with disabled children, from senior management to ancillary staff, should be trained in disability equality and those having direct contact with young people need training in communicating with disabled children and at least basic training in protecting them. Schools must ensure that disabled children have the same opportunities as other pupils to receive sex and relationship education, suitably adapted for those with intellectual disabilities, in order to increase their knowledge and awareness of "normal," acceptable behaviour: safety skills training is also vital. Disabled children should be actively involved in the child protection process as far as their age and ability allows, with credence given to their accounts and full consideration of their views. The UK Equality Act (2010) makes it illegal for

children to receive a “less favourable” child protection service than others on the grounds of impairment and, in many countries worldwide, child protection practice with disabled children must be informed by international conventions regarding the rights of children (UN, 1989) and disabled people (UN, 2006).

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